FOR OHF USE

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2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0045765

Facility Name: Nature Trail HealthCare Center

Address: 1001 South 34th Street (Number) Mt. Vernon (City) 62864 (Zip Code)

County: Jefferson

Telephone Number: (618) 242-5700 **Fax #** (618) 242-5705

IDPA ID Number: 38-1923423001

Date of Initial License for Current Owners: 06/07/1994

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		X	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Chris Henderson **Telephone Number:** (832) 467-6307

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2004 to 12/31/2004 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) Greg Williams

(Title) Reimbursement Manager

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title) N/A

(Firm Name & Address)

(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Nature Trail HealthCare Center # 0045765 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	19	Skilled (SNF)	19	6,954	1
2		Skilled Pediatric (SNF/PED)			2
3	55	Intermediate (ICF)	55	20,130	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	74	TOTALS	74	27,084	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	33	116	5,580	5,729	8
9	SNF/PED					9
10	ICF	13,565	3,267	840	17,672	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	13,598	3,383	6,420	23,401	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.40%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 06/07/1994

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 06/07/1994 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 19 and days of care provided 5,511

Medicare Intermediary Mutual Omaha

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2004 Fiscal Year: 12/31/2004

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Nature Trail HealthCare Center # 0045765 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	129,409	10,308	8,920	148,637		148,637		148,637			1
2	Food Purchase		99,502		99,502	(968)	98,534		98,534			2
3	Housekeeping	81,021	5,975	286	87,282		87,282		87,282			3
4	Laundry	35,007	4,526	49	39,582		39,582		39,582			4
5	Heat and Other Utilities			54,180	54,180		54,180	114	54,294			5
6	Maintenance	20,027	33,630	4,614	58,271		58,271	62	58,333			6
7	Other (specify):* Waste/Garbage See pg 3.1			11,965	11,965		11,965		11,965			7
8	**TOTAL General Services**	265,464	153,941	80,014	499,419	(968)	498,451	176	498,627			8
	B. Health Care and Programs											
9	Medical Director			6,700	6,700		6,700		6,700			9
10	Nursing and Medical Records	892,961	54,872	19,661	967,494		967,494	15,419	982,913			10
10a	Therapy	287,630	42,445	17,846	347,921		347,921		347,921			10a
11	Activities	30,277	2,563	2,558	35,398		35,398		35,398			11
12	Social Services		241	2,207	2,448		2,448		2,448			12
13	Nurse Aide Training											13
14	Program Transportation			2,737	2,737	(2,737)						14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,210,868	100,121	51,709	1,362,698	(2,737)	1,359,961	15,419	1,375,380			16
	C. General Administration											
17	Administrative	74,646			74,646		74,646		74,646			17
18	Directors Fees											18
19	Professional Services			6,082	6,082		6,082		6,082			19
20	Dues, Fees, Subscriptions & Promotions			22,787	22,787		22,787	(1,054)	21,733			20
21	Clerical & General Office Expenses	102,546	7,837	220,922	331,305		331,305	(44,975)	286,330			21
22	Employee Benefits & Payroll Taxes			330,990	330,990	968	331,958	(968)	330,990			22
23	Inservice Training & Education											23
24	Travel and Seminar			25,404	25,404		25,404	7,394	32,798			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			77,877	77,877		77,877	(41,607)	36,270			26
27	Other (specify):* X-ray/Lab Pg 4.1											27
28	**TOTAL General Administration**	177,192	7,837	684,062	869,091	968	870,059	(81,210)	788,849			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,653,524	261,899	815,785	2,731,208	(2,737)	2,728,471	(65,615)	2,662,856			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

SUPPLEMENTAL SCHEDULE OF OTHER EXPENSES

Operating Expense - Line 7	Amount
Infectious Waste Disposal <> Default <> Nursing Admin/Supv	9,796
Infectious Waste Disposal <> Default <> Physical Plant	0
Garbage Service<>Default<>Prod<>Physical Plant	2,172
Garbage Service <> Default <> Physical Plant	0
	11,968

Health Care Program - Line 15	Amount
N/A	
	0

General & Adminstrative - Line 27	Amount
N/A	
	0

Inservice Education - Line 23 Column 3 (over $2,000)	Amount
N/A	
	0

Meals - adjustment

23,401	Days (Total Patient days)
3	Mult (3 meals a day)
70203	Sub total
690	meals to employess (reported by facility)
70893	Add Sub
99,502	Divide -Pg 3, line 2, column 2
1.40	Cost per day

1.40	Cost per day
690	mult - meal to employees
968	= adjust for pg 2, line 2, column2

Sales Tax - adjustment

99,502	Total Food Cost (page 3,Line 2, col 3)
0.01	Mult
995.02	Sub total
24.48%	Mult (Pvt pay div by total census)
244	= adjust for nonallowable sale tax for page 5A,

122 = adjust for nonallowable sale tax

Reclassifiaction V

Page 3 Line 14

Res/Client Transportation<>Default<>Prod<>Transport 810004000003850	(2,737)	Reclass From
Page 4 line 38	2,737	Reclass to

SUPPLEMENTAL SCHEDULE OF OTHER EXPENSES

Ownership - Line 36	Amount
Fresh Start Acctg Adj <> Bankrupty Exp Acq <> Cost Non Overhead	0
	-

Ancillary Expenses - Line 43 -Column 2	Amount
Ancillary Cost of Goods Sold<>Default<>Prod<>Laboratory	0
	0

Ancillary Expenses - Line 43 -Column 3	Amount
Professional Services <> Nonchg<>Other Medical Professionals<>Labora	18,097
Professional Services <> Nonchg<>Physician Xray	18
Professional Services <> Nonchg<>Other Medical Professionals<>X/Ray	13,416
Professional Services <> Nonchg<>Medical Director<>Laboratory	0
Professional Services <> Nonchg<>Medical Director<>X/Ray	0
Professional Services <> Nonchg<>Other Medical Professionals<>Labora	0
Professional Services <> Nonchg<>Other Medical Professionals<>X/Ray	0
	31,531

Facility Name & ID Number Nature Trail HealthCare Center #0045765 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			45,637	45,637		45,637	68,971	114,608			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			(222)	(222)		(222)	222				32
33	Real Estate Taxes			22,968	22,968		22,968	(2,583)	20,385			33
34	Rent-Facility & Grounds							4,986	4,986			34
35	Rent-Equipment & Vehicles			1,167	1,167		1,167	947	2,114			35
36	Other (specify):* Home Office							7,629	7,629			36
37	**TOTAL Ownership**			69,550	69,550		69,550	80,172	149,722			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation					2,737	2,737	(2,737)				38
39	Ancillary Service Centers		140,508	1,538	142,046		142,046	19,054	161,100			39
40	Barber and Beauty Shops		299	7,826	8,125		8,125	(8,125)				40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			40,626	40,626		40,626		40,626			42
43	Other (specify):* X-ray/Lab Pg 4.1			31,531	31,531		31,531		31,531			43
44	**TOTAL Special Cost Centers**		140,807	81,521	222,328	2,737	225,065	8,192	233,257			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,653,524	402,706	966,856	3,023,086		3,023,086	22,749	3,045,835			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Nature Trail HealthCare Center # 0045765 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(968)	22		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	222	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(2,269)			24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(160,505)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (163,520)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	184,000		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 184,000		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 20,480		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.	x		$ 2,737	38	38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$ 2,737		47

STATE OF ILLINOIS

Nature Trail HealthCare Center

ID# 0045765

Report Period Beginning: 01/01/2004

Ending: 12/31/2004

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Sales Taxes	$ (122)	21	1
2	Small Balance Adjustment		21	2
3	Memorium/ Benevolance	204	21	3
4	Depreciation Reconciliation	68,971	30	4
5	Activities Program Receipts		11	5
6	Barber & beauty	(8,125)	40	6
7	Professional liability Insurance	(41,607)	26	7
8	Barber & beauty		40	8
9	Public Relations Expenses		20	9
10	Non Allowable Advertising	(1,407)	20	10
11	Entertaiment	(121)	24	11
12	Fresh Start		36	12
13	Civic Dues	(250)	20	13
14	Penalities		21	14
15	Vending reciepts	(658)	21	15
16	Misc Reciepts	(1,066)	21	16
17	Marketing Wages		21	17
18	Marketing Bonus	5,726	21	18
19	Marketing Holiday		21	19
20	Maketing Sick		21	20
21	Marketing Vacation		21	21
22	Marketing Overtime		21	22
23	Marketing Non Worked Wages		21	23
24	Donations/ Contributions		21	24
25	Legal Fees - Bankrupcty		21	25
26	Legal Structure Management Fees	(176,324)	21	26
27	Property Tax Adjustment to Actual	(2,989)	33	27
28	Travel logs missing		24	28
29				29
30	**Transporation**	(2,737)	38	30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(160,505)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Nature Trail HealthCare Center # 0045765 **Report Period Beginning:** 01/01/2004 **Ending:** 12/31/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	114	0	0	0	0	0	0	0	0	0	114	5
6	Maintenance	0	62	0	0	0	0	0	0	0	0	0	62	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	176	0	0	0	0	0	0	0	0	0	176	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	15,419	0	0	0	0	0	0	0	0	0	15,419	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	15,419	0	0	0	0	0	0	0	0	0	15,419	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(1,657)	603	0	0	0	0	0	0	0	0	0	(1,054)	20
21	Clerical & General Office Expenses	(172,240)	127,265	0	0	0	0	0	0	0	0	0	(44,975)	21
22	Employee Benefits & Payroll Taxes	(968)	0	0	0	0	0	0	0	0	0	0	(968)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(121)	7,515	0	0	0	0	0	0	0	0	0	7,394	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(41,607)	0	0	0	0	0	0	0	0	0	0	(41,607)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(216,593)	135,383	0	0	0	0	0	0	0	0	0	(81,210)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(216,593)	150,978	0	0	0	0	0	0	0	0	0	(65,615)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number Nature Trail HealthCare Center **#** 0045765 **Report Period Beginning:** 01/01/2004 **Ending:** 12/31/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	68,971	0	0	0	0	0	0	0	0	0	0	68,971	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	222	0	0	0	0	0	0	0	0	0	0	222	32
33	Real Estate Taxes	(2,989)	406	0	0	0	0	0	0	0	0	0	(2,583)	33
34	Rent-Facility & Grounds	0	4,986	0	0	0	0	0	0	0	0	0	4,986	34
35	Rent-Equipment & Vehicles	0	947	0	0	0	0	0	0	0	0	0	947	35
36	Other (specify):*	0	7,629	0	0	0	0	0	0	0	0	0	7,629	36
37	**TOTAL Ownership**	66,204	13,968	0	0	0	0	0	0	0	0	0	80,172	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	(2,737)	0	0	0	0	0	0	0	0	0	0	(2,737)	38
39	Ancillary Service Centers	0	19,054	0	0	0	0	0	0	0	0	0	19,054	39
40	Barber and Beauty Shops	(8,125)	0	0	0	0	0	0	0	0	0	0	(8,125)	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	(10,862)	19,054	0	0	0	0	0	0	0	0	0	8,192	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(161,251)	184,000	0	0	0	0	0	0	0	0	0	22,749	45

Facility Name & ID Number Nature Trail HealthCare Center # 0045765 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Mariner Health Care	100	See Attachment page 6.1		Mariner Health Care	Alanta, GA	Management

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	5	Utilities	$	Mariner Health Care	100.00%	$ 114	$ 114	1
2	V	6	Repair & Maintenance		Mariner Health Care	100.00%	62	62	2
3	V	39	Professional Services		Mariner Health Care	100.00%	19,054	19,054	3
4	V	20	Fees, Subscriptions, Promotions		Mariner Health Care	100.00%	603	603	4
5	V	10	Nursing & Medical Records		Mariner Health Care	100.00%	15,419	15,419	5
6	V	21	Clerical & General Office Exp		Mariner Health Care	100.00%	127,265	127,265	6
7	V	24	Travel & Seminar		Mariner Health Care	100.00%	7,515	7,515	7
8	V	26	Insurance Premium		Mariner Health Care	100.00%			8
9	V	36	Depreciation		Mariner Health Care	100.00%	7,629	7,629	9
10	V	33	Taxes - Property		Mariner Health Care	100.00%	406	406	10
11	V	35	Rental & Leasing		Mariner Health Care	100.00%	947	947	11
12	V	34	Leasse Expense		Mariner Health Care	100.00%	4,986	4,986	12
13	V	26	Property Insurance		Mariner Health Care	100.00%			13
14	Total			$			$ 184,000	$ * 184,000	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Related Illinois Nursing Homes as of 12/31/2004

Group Name	Related Illinois Nursing Homes	Illinois Facility Number
Mariner Health Care	LaSalle Health & Rehabilitation Center	0037671
	Litchfield HealthCare Center	0037689
	Montebello Healthcare Center	0031468
	Nature Trail HealthCare Center	0039586
	Odin HealthCare Center	0039503
	Mariner Health of Westchester	0042374

Facility Name & ID Number Nature Trail HealthCare Center # 0045765 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Nature Trail HealthCare Center # 0045765 Report Period Beginning: 01/01/2004 Ending: 2/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Mariner Health Care
Street Address: One Ravine Dr. Suite 1500
City / State / Zip Code: Atlanta, GA 30346
Phone Number: ((770) 379-8203
Fax Number: ((770) 399-1971

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Utilities		1		$ 114	$	1	$ 114	1
2	6	Repair & Maintenance		1		63		1	62	2
3	39	Professional Services		1		19,054		1	19,054	3
4	20	Fees, Subscriptions, Promotions		1		603		1	603	4
5	10	Nursing & Medical Records		1		15,419		1	15,419	5
6	21	Clerical & General Office Exp		1		127,265		1	127,265	6
7	24	Travel & Seminar		1		7,515		1	7,515	7
8	26	Insurance Premium		1				1	0	8
9	36	Depreciation		1		7,629		1	7,629	9
10	33	Taxes - Property		1		406		1	406	10
11	35	Rental & Leasing		1		947		1	947	11
12	34	Leasse Expense		1		4,986		1	4,986	12
13	26	Property Insurance								13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 184,001	$		$ 184,000	25

Facility Name & ID Number Nature Trail HealthCare Center # 0045765 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Nature Trail HealthCare Center # 0045765 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 22,287	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 19,979	2
3. Under or (over) accrual (line 2 minus line 1).		$ (2,308)	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 25,276	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 22,968	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1999	19,647	8
	2000	19,494	9
	2001	19,329	10
	2002	19,726	11
	2003	19,979	12

#4… G/L accrual for Property taxes

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Nature Trail HealthCare Center COUNTY Jefferson

FACILITY IDPH LICENSE NUMBER 0045765

CONTACT PERSON REGARDING THIS REPORT Chris Henderson

TELEPHONE (832) 467 6307 FAX #: (832) 467-6349

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	06-36-327-006	77-1-079-04 PT NE SW-BEG 330.6"	$ 19,978.78	$ 19,978.78
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 19,978.78	$ 19,978.78

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

Facility Name & ID Number Nature Trail HealthCare Center # 0045765 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 17,558 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred:
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization:
4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	225,000	1994	$ 50,246	1
2					2
3	TOTALS	225,000		$ 50,246	3

Facility Name & ID Number Nature Trail HealthCare Center # 0045765 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	74		1994		$ 2,213,241	$ 63,235	35	$ 63,235	$	$ 668,362	4
5			1994		329,317	16,465	20	16,465		173,456	5
6											6
7											7
8											8
	Improvement Type**										
9	Interior Building Improvements			1995	2,325	233	20	233		2,195	9
10	Unit Heaters			1996	642	64	20	64		538	10
11	Flooring - Tile			1996	2,384	119	20	119		973	11
12	Heater BaseBoard - 6			1996	502	50	20	50		403	12
13	Drapes / Valances			1996	3,956	396	20	396		3,168	13
14	Smoke Detectors			1996	2,880	288	20	288		2,370	14
15	Sude rails			1996	1,149	57	20	57		422	15
16	Parking Repairs			1997	1,923	96	20	96		699	16
17	Wall Covering			1997	897	45	20	45		346	17
18	Gutters			1997	2,290	115	20	115		824	18
19	Beauty Salon			1997	1,040	52	20	52		378	19
20	Sewer Tile			1997	1,575	79	20	79		628	20
21	A/C Heater Unit			1997	591	59	20	59		421	21
22	Water Heater			1997	388	19	20	19		133	22
23	Floor Preparation			1997	650	33	20	33		257	23
24	Floor Covering			1997	1,460	73	20	73		570	24
25	Floor Finishing			1997	250	13	20	13		101	25
26	Water Heater			1997	388	39	20	39		279	26
27	Rebuilding Bathroom			1997	3,825	191	20	191		1,368	27
28	Cabinets / Millwork			1998	161	8	20	8		56	28
29	Heating / Ventilating			1998	592	30	20	30		154	29
30	5 - Heater W/Adapters #86			1999	2,269	227	20	227		1,210	30
31	Repair Water Leak - Kitchen #106			2000	1,334	67	20	67		306	31
32	Repair Water Line - Booster Heater #107			2000	986	49	20	49		225	32
33	See Attached 12.1 Supplemental					69,276			(69,276)		33
34	30 - Amp Filters, W/G System & Use Tax #110 & 111			2001	243	24	10	24		95	34
35	Wanderguard System #112			2001	6,263	626	10	626		2,452	35
36	Use Tax Wanderguard System #113			2001	58	6	10	6		23	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Nature Trail HealthCare Center # 0045765 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Thru Wall Heat / Cool Units #116	2001	$ 2,131	$ 426	5	$ 426	$	$ 1,421	37
38	Use Tax %: Thru Wall Heat /Cool Units #117	2001	149	30	5	30		99	38
39	3 Ton Condenser, East Wing & Use Tax 118 & 119	2001	861	57	15	57		200	39
40									40
41	Win Freezer Condenser Instl #123	2002	3,021	201	15	201		621	41
42	Instl Grease Interceptor #129	2002	4,871	243	20	243		750	42
43	Wanderguard System & Use Tax #132 & 133	2002	6,227	623	10	623		2,284	43
44	CR Inc # 1000017826/ Discount #134	2002	(22)	(2)	10	(2)		(8)	44
45	CR Inc # 1000017900 W/G System Discount #135	2002	(349)	(35)	10	(35)		(125)	45
46	Maglock Brackets #136	2002	151	15	10	15		55	46
47	Maglocks Brackets #137	2002	151	15	10	15		55	47
48	CR Inv 10015138 Corby Push #138	2002	(95)	(9)	10	(9)		(34)	48
49	Wanderguard System & Use Tax #5007 & 2008	2002	1,268	127	10	127		455	49
50	Cr - Labor charge Wanderguard #5009	2002	(1,200)	(120)	10	(120)		330	50
51	Charge Excess Discount Wanerguard #5010	2002	52	5	10	5		18	51
52	4: Heat / Cool Units Use Tax #5013 & 5014	2002	1,959	229	5	229		458	52
53	Rplc 5 ton AirHandler, Condenser #5021	2002	6,746	281	10	281		562	53
54									54
55	New Roof #5030	2003	23,935	2,394	10	2,394		4,986	55
56	Storage Building 10x21 #5031	2003	1,900	190	10	190		348	56
57	Rprc Russes - Kitchen #5034	2003	2,600	173	15	173		318	57
58	Fire Sprinkler Retrofit Apl # 5048	2003	4,644	128	25	128		128	58
59									59
60	Fire Suppression Syst- Kitchen	2204	1,275	128	10	128		128	60
61	Maglock-WanderGuard System	2004	1,493	75	10	75		75	61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,645,347	$ 157,208		$ 87,932	$ (69,276)	$ 875,536	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Nature Trail HealthCare Center # 0045765 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 466,293	$ 25,801	$ 25,801	$		$ 252,287	71
72	Current Year Purchases	9,076	875	875			875	72
73	Fully Depreciated Assets	(220,696)						73
74								74
75	TOTALS	$ 254,673	$ 26,676	$ 26,676	$		$ 253,162	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 2,950,266	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 183,884	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 114,608	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (69,276)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,128,698	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	O/H Allocation 06/01/1996	$ 1,583	$ 79	$ 586	86
87	O/H Allocation 12/01/1996	568	28	203	87
88	O/H Allocation 08/01/1997	277	14	120	88
89	O/H Allocation 10/01/1997	965	48	320	89
90					90
91	TOTALS	$ 3,393	$ 169	$ 1,229	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	N/A			$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
    Beginning ____
    Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO
16. Rental Amount for movable equipment: $ 13,365 Description: See Attachment pg 14.1
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	N/A		$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SUPPLEMENTAL SCHEDULE - Page 14 -B -16 - EQUIPMENT -RENTAL MOVABLE

Name of G/L	G/L #	EQUIPMENT	Amount		Page/Line/Col Ref From
Lease Exp - Eqpt - Nonmedical <> Default <> NonCert	841000000001011	Specialty Mattress	5411.48		03/10/03
Lease Exp - Eqpt - <> Default <> Equip Rental	841000000002102				03/10/03
Lease Exp - Eqpt - Nonmedical <> Default <> Activities	841000000007000				03/11/03
Lease Exp - Eqpt - Nonmedical <> Default <> Dietary	841000000007030	Diswasher			03/01/03
Lease Exp - Eqpt - Nonmedical <> Default <> Housekeepin	841000000007040				03/03/03
Lease Exp - Eqpt - Nonmedical <> Default <> Laundry	841000000007050				03/04/03
Lease Exp - Eqpt - Nonmedical <> Default <> Nursing Admi	841000000008000	Mattress	183.81		03/10/03
Lease Exp - Eqpt - Nonmedical <> Default <> Administrative	841000000008100	Copies, Stamp machine Cable	6,602.54		03/21/03
Lease Exp - Eqpt - Nonmedical <> Default <> Physical Plan	841000000008210				03/05/03
Lease Exp - Eqpt - Nonmedical <> Default <> Realty	841000000008220	Parking Lot	1,166.69		04/35/03
Lease Exp - Other <> Default <> Administrative	841020000008100				03/21/03
			13,364.52		Grand Total

Facility Name & ID Number Nature Trail HealthCare Center # 0045765 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a-03	3492 hrs	$ 88,974		$	$	3,492	$ 88,974	1
2	Licensed Speech and Language Development Therapist	10a-03	2172 hrs	67,271				2,172	67,271	2
3	Licensed Recreational Therapist	10a-03	hrs							3
4	Licensed Physical Therapist	10a-03	4817 hrs	117,694				4,817	117,694	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39	# of prescrpts				140,508		140,508	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$ 273,939		$	$ 140,508	10,481	$ 414,447	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Nature Trail HealthCare Center **#** 0045765 **Report Period Beginning:** 01/01/2004 **Ending:** 12/31/2004

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2004 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,100	$	1
2	Cash-Patient Deposits	64,355		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	607,104		3
4	Supply Inventory (priced at)	10,025		4
5	Short-Term Investments			5
6	Prepaid Insurance	200		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 682,784	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	110,000		13
14	Buildings, at Historical Cost	470,029		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	144,152		16
17	Accumulated Depreciation (book methods)	(117,725)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 606,456	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,289,240	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 75,622	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	(821)		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	98,426		30
31	Accrued Taxes Payable (excluding real estate taxes)	5,214		31
32	Accrued Real Estate Taxes(Sch.IX-B)	22,968		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attachment pg 17.1	1,442		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 202,851	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attachment pg 17.1	(1,124,270)		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ (1,124,270)	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ (921,419)	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,210,659	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,289,240	$	48

***(See instructions.)**

SUPPLEMENATAL SCHEDULE OF ASSETS & LIABILITIIES

OTHER CURRENT ASSETS:	AMOUNT
Total	0
Reconcile with schedule XV, line 9:	0
Difference	0

OTHER CURRENT LIABILITIES:	AMOUNT
Misc Dedctns - Employee <> Other Decductions <> Default	-
Misc Dedctns - Employee <> Union Dues <> Default	
Accruals - Insurance <> Accrue HMO Ins <> Default	
Accruals - Insurance <> Self Funded Ins Accr <> Default	
Accruals - Insurance <> Basic Life <> Default	527
Accruals - Insurance <> Lt Dsblty <> Default	198
Accruals - Insurance <> Dental Ins <> Default	-
Accruals - Insurance <> Executive Supp Life <> Default	295
Accruals - Insurance <> Short Term Disability <> Default	(37)
Accruals - Insurance <> Dependent Life <> Default-Dept	50
Accruals - Insurance <> Accidental Death Dismemberment <> Default-Dept	22
Accruals - Insurance <> NES Insurance <> Default-Dept	-
Accruals - Benefits <> 401k Co Match <> Default	388
Total	1,443
Reconcile with schedule XV, line 36:	1,443
Difference	-

OTHER NON-CURRENT ASSETS:	
Excess Reorganized Value <>Excess Reorg Value <> Default	
Other Assets <> Rfndable Deposits-Non Int Brg <> Default	
Total	-
Reconcile with schedule XV, line 23:	0
Difference	-

OTHER NON-CURRENT LIABILITIES::	
Intercompany - Revolver <> Default <> Default	(1,124,270)
N/P - Mortgage <> Mortgages <> Default	
Total	(1,124,270)
Reconcile with schedule XV, line 43:	(1,124,270)
Difference	0

Facility Name & ID Number Nature Trail HealthCare Center # 0045765 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,692,637	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,692,637	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	518,022	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 518,022	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 2,210,659	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Nature Trail HealthCare Center # 0045765 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,907,745	1
2	Discounts and Allowances for all Levels	(1,767,863)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,139,882	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,029,561	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,029,561	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	9,128	13
14	Non-Patient Meals	3,772	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	281,198	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	46,962	19
20	Radiology and X-Ray	10,189	20
21	Other Medical Services	18,691	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 369,940	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc Receipts & Rental Receipts (See Pg 19.1)	658	28
28a	Misc Receipts (See Pg 19.1)	1,066	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,724	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,541,107	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	499,419	31
32	Health Care	1,362,698	32
33	General Administration	869,091	33
	B. Capital Expense		
34	Ownership	69,550	34
	C. Ancillary Expense		
35	Special Cost Centers	181,701	35
36	Provider Participation Fee	40,626	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,023,085	40
41	**Income before Income Taxes (line 30 minus line 40)****	518,022	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 518,022	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

SUPPLEMENATAL INCOME SCHEDULE

DESCRIPTION	AMOUNT
Personal Purchase Receipts <> Default <> Vending	658
Miscellaneous Receipts<>Default<>Prod<>Vending	
Miscellaneous Receipts<>Default<>Prod<>Administrative	-

Total	658.00	Difference
Reconcile with schedule XVII, line 28:	658	0

DESCRIPTIONS	
Personal Purchase Receipts <> Default <> Patient Personal Purchase	-
Personal Purchase Receipts <> Default <> Miscellaneous Receipts	-
Personal Purchase Expense <> Default <> Patient Personal Purchase	-
Miscellaneous Receipts <> Default-Prod <> Other Misc Rev	-
Activity Programs Receipts <> Default <> Other Misc Rev	-
Miscellaneous Receipts<>Default<>Prod<>Activities	1,066

Total	1,066	Difference
Reconcile with schedule XVII, line 28a:	1,066	-

Facility Name & ID Number Nature Trail HealthCare Center # 0045765 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,383	2,450	$ 62,006	$ 25.31	1
2	Assistant Director of Nursing					2
3	Registered Nurses	7,840	8,060	147,017	18.24	3
4	Licensed Practical Nurses	12,356	12,703	187,574	14.77	4
5	Nurse Aides & Orderlies	44,902	43,163	441,502	10.23	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	5,512	5,774	123,150	21.33	7
8	Rehab/Therapy Aides	5,030	5,268	164,480	31.22	8
9	Activity Director	2,084	2,105	22,521	10.70	9
10	Activity Assistants	1,332	1,346	7,756	5.76	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	2,070	2,098	31,864	15.19	13
14	Head Cook	5,930	6,011	56,315	9.37	14
15	Cook Helpers/Assistants	5,473	5,547	41,230	7.43	15
16	Dishwashers					16
17	Maintenance Workers	2,272	2,324	20,027	8.62	17
18	Housekeepers	9,668	9,927	81,021	8.16	18
19	Laundry	5,268	5,387	35,007	6.50	19
20	Administrator	2,266	2,311	73,038	31.60	20
21	Assistant Administrator					21
22	Other Administrative	2,985	3,044	48,683	15.99	22
23	Office Manager					23
24	Clerical	5,089	5,191	61,196	11.79	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,534	1,653	13,167	7.97	31
32	Other Health Care(specify)	2,049	2,049	41,694	20.35	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	126,043	126,411	$ 1,659,248 *	$ 13.13	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	223	$ 8,920	1-3	35
36	Medical Director	107	6,700	9.3	36
37	Medical Records Consultant	10	441	10-3	37
38	Nurse Consultant	294	15,419	10-7	38
39	Pharmacist Consultant	49	2,120	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	47	2,558	11-3	44
45	Social Service Consultant	40	2,207	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	770	$ 38,365		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Nature Trail HealthCare Center # 0045765 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Mark Fedyk	Administrator	100	$ 63,570
Henry Douglas	Administrator-Interim	100	11,076
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 74,646

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
See Exhibit 1	See Exhibit 1	$ 6,082
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 6,082

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 76,240
Unemployment Compensation Insurance	45,954
FICA Taxes	122,669
Employee Health Insurance	80,507
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Pension / retirment	637
Insurance Life	2,133
Other Benefits	2,850
Home Office Allocation	
Less: Employee meals	
TOTAL (agree to Schedule V, line 22, col.8)	$ 330,990

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	12,880
Health Care Worker Background Check	
(Indicate # of checks performed)	2,060
Other Licenses Fees	2,194
Dues	4,174
Rounding	
Home Office Allocation	602
Total Advertising	1,480
Less: Public Relations Expense	(250)
Non-allowable advertising	(1,407)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 21,733

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 601
In-State Travel	23,586
Home Office allocation	7,515
Seminar Expense	1,217
Entertainment Expense	(121)
TOTAL (agree to Sch. V, line 24, col. 8)	$ 32,798

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Nature Trail HealthCare Center # 0045765 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Nature Trail HealthCare Center # 0045765 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois Health Care Association -$3,552**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **5**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **3,943** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **40,626**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **968** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **968**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **Yes**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **N/A** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm?
Firm Name: **N/A** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **N/A** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.